TOBACCO FREE OHIO ALLIANCE

2020-2025

STRATEGIC PLAN FOR A TOBACCO FREE OHIO

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Preface

A note on language: Some American Indian or First Nation tribes use tobacco as a sacred medicine and in ceremony to promote physical, spiritual and community well-being. Sacred tobacco is traditionally grown by First Nations tribes. Sacred tobacco is different from commercial tobacco, which is tobacco that is manufactured and sold by the commercial tobacco industry, and is linked to addiction, disease, and death. Commercial tobacco is mass produced and sold for profit. When the report references tobacco we are referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities. To learn more, visit https://keepitsacred.itcmi.org/

Executive summary

While Ohio has made advances in reducing tobacco use and exposure,
commercial tobacco is the single most preventable cause of death and disease in the United States and in Ohio.[1]

- Each year, 20,200 Ohioans die from smoking-related illness.[2]
- 259,000 kids under 19 and alive in Ohio will ultimately prematurely die from smoking-related causes.[3]

In addition to the toll on the lives of Ohioans, there is a monetary cost:

- The annual health care costs directly caused by smoking is **$5.64 billion.**[4]
- Annual Medicaid costs caused by smoking is **$1.72 billion.**[5]
- And, residents' state and federal tax burden from smoking-caused government expenditures is **$793 per household.**[6]

And, we know the **impact from tobacco use and addiction is not evenly distributed**. The burden of tobacco impacts specific populations. This plan seeks to eliminate those disparities.[7]

Mental health
People who experience frequent (15 days or more a month) poor mental health days have smoking rates that are nearly double (34%) the smoking rates of people who infrequently experience poor mental health days (18.1%).

34%

Substance Abuse
Binge drinkers smoke cigarettes (33.6%) at almost double the rate of non-binge drinkers (15.4%).

almost 2x

Race
Black, non-Hispanic (25.2%) people have a higher smoking rate than white, non-Hispanic people (20.4%); however this difference is not significant.

5% higher

Income
1 in 10 people that make less than $75,000/year smoke, compared to approximately 2 in 5 people that make less than $15,000.

4x

Pregnant Women
17.3% of women in Ohio smoke at some point during their pregnancy.

17%

▶ Secondhand Smoke Exposure

42%

42.0% of Ohio adults report exposure to secondhand smoke from cigarettes in the past 7 days and 21.6% report exposure to secondhand vapor in the last 7 days.

- Living with Disability: 45.6%
- Did not Graduate High School: 52.9%
- Binge Drinkers: 58.0%
- 14+ Mental Health Days/Month: 58.9%

▶ Youth[8]:

88% increase

- Tobacco use among middle school and high school students in Ohio increased 88% from 2016 (16.1%) to 2019 (30.3%).
  - Middle school: 125% increase
  - High school: 52% increase
- E-cigarettes are the most commonly used tobacco product among both middle school and high school students in Ohio.
  - Middle school: 11.9% use e-cigarettes
  - High school: 29% use e-cigarettes

Therefore, commercial tobacco prevention and control is still a high priority in Ohio as the state ranks as the 9th highest in the nation for adult smoking (BRFSS, 2019). The estimated prevalence of current smokers in Ohio is 20.8%, compared to 16.0% nationwide.[9] Furthermore, the estimated prevalence of current smokeless tobacco use in Ohio is 4.8% compared to 2.4% nationwide.[10] The estimated prevalence of current e-cigarettes use in Ohio is 4.6%. And, there are still disparities.

The Strategic Plan for a Tobacco Free Ohio, 2020-2025 is a product of the Tobacco Free Ohio Alliance (TFOA) and its advisory panel and membership, as well as other technical advisors. (A list of contributors can be found in the appendix.) The Plan is organized into five priority areas with objectives and strategies for achieving each priority. The plan includes specific goals to be reached by December 2025, including targets within specific populations. The five priority areas are as follows:

Ohio has the **ninth highest adult smoking rate** in the U.S.

1 Prevent Youth Tobacco Use

- Limit access and availability of tobacco products to youth, including flavored products
- Increase K-12 schools with 100% tobacco-free policies.
- Equalize the tax on electronic nicotine delivery systems to the state tax on cigarettes.

2 Promote Tobacco Cessation

- Increase cessation services and utilization through provider engagement.
- Increase overall enrollment in the Ohio Quitline and My Life, My Quit.
- Decrease disparities in adult smoking rates.

3 Eliminate Exposure to Secondhand Smoke

- Decrease Ohioans' exposure to secondhand smoke in homes, schools, worksites, and other outdoor spaces.
- Increase the percentage of Mental Health and Substance Abuse facilities with 100% tobacco and nicotine-free policies.

4 Develop and Maintain Sustainable Infrastructure

- Increase collaboration and engagement with TFOA members, ODH local tobacco grantees, and other partners and stakeholders to address the burden of tobacco.
- Identify geographic regions or counties with high disparities and increase awareness of need and resources to achieve equity for tobacco prevention and cessation.
- Increase utilization of data to address tobacco use prevention and cessation.

5 Investigate, Monitor, and Evaluate Issues Associated with Tobacco Use

- Promote the use of Ohio's Tobacco Surveillance System, assure regular release of accurate data about tobacco's burden on Ohio, regularly evaluate the activities of Ohio's Comprehensive Tobacco Program and promote research and the dissemination of applicable results.
- Increase use of innovative strategies for collaborative and local data collection through increased partnerships.

The members of Tobacco Free Ohio Alliance (TFOA) believe the Strategic Plan for a Tobacco Free Ohio provides an important foundation for comprehensive prevention and control of commercial tobacco use. The plan serves to identify a common vision and mission for the work of many partners. This common vision and mission will help to align and focus work being done by stakeholders in different roles throughout the state. It also seeks to address disparities in populations with higher use rates and experiences a higher burden of disease and death from commercial tobacco use. We hope the Plan also helps to focus combined work on priority objectives and sets clear goal posts to measure progress over time. TFOA hopes the Plan will serve to bring stakeholders together to prevent duplication of effort, as well as to provide for the identification of opportunities to integrate and collaborate in order to conserve and leverage limited resources.

Letter from the Chair

Dear Ohioans,

Tobacco use is the number one leading cause of preventable death and disease in the United States, and impacts our health, finances, the environment, and our overall quality of life. Per the State Health Assessment (SHA), approximately 21.1 % of Ohioans are current smokers (v. 17.1 % nationwide), 7.8 % of Ohio children are exposed to secondhand smoke (v. 2.7 % nationwide), and smoking during pregnancy is an estimated 14.0% (v. 7.2 % nationwide).

Despite the initiation of the Tobacco 21 law effective October 17, 2019, raising the age of purchase for nicotine products, including tobacco products and vapor products, from 18 years of age to 21, there is still much work to be done to prevent tobacco initiation and to assist Ohioans with cessation interventions. Upon review of the previous tobacco control activities, strategies, and successes, in order to reduce tobacco use and exposure, the 2020-2025 Tobacco Free Ohio Alliance (TFOA) Strategic Plan identifies five priority areas necessary to combat tobacco use, including: State and Community Interventions, Mass-Reach Health Communication, Cessation Interventions, Surveillance and Evaluation, and Infrastructure, Administration, and Management.

The 2020-2025 TFOA Strategic Plan will continue to address tobacco prevention initiatives through educating and engaging the community, promoting and strengthening policies limiting the availability of and accessibility to tobacco products, and reducing citizens' exposure to secondhand smoke. Health communications disseminated through various medium will allow for the communication of health interventions and assist in promoting the cessation services available for Ohioans, locally and statewide. Data surveillance and evaluation ensure the Strategic Plan continues to align with the objectives to minimize the impact of tobacco use and secondhand smoke and maximizing the use of resources to decrease the health burden of tobacco use in Ohio.

Through the coordination of efforts and partnerships, we will continue to work together to create a healthier Ohio.

Caitlin Mathews

Caitlin Mathews
Chair
Tobacco Free Ohio Alliance

The Burden of Tobacco in Ohio

According to 2019 data from the Behavioral Risk Factor Surveillance System (BRFSS), Ohio's adult smoking rate is 20.8%, 9th highest among US states and higher than the US adult smoking rate of 16.0%.[11] This phenomenon is not limited to adults, as approximately 30,000 high school students in Ohio are current smokers, and an additional 4,000 children under the age of 18 in Ohio become smokers each year.

The issue of tobacco use goes beyond smoking, however. The rapid rise and popularity of e-cigarettes have created new challenges. Adult use of e-cigarettes or vaping devices is 5.4%, higher than the national average of 3.2%. It is also extremely popular among youth populations, where 29.8% of high school students use e-cigarettes, nearly six times the rate of adult use in Ohio. Nicotine in adolescence can harm the parts of the brain that control attention, learning, mood, and impulse control.[12] We know that nicotine affects the way a young person's brain functions. The Ohio Department of Mental Health and Addiction Services reports that young people who consistently smoke throughout adolescence are at significantly greater risks for use of alcohol, marijuana, and abuse or dependence on other drugs. Research links smoking in adolescence to earlier onset and more episodes of major depressive disorder, anxiety disorders, and other mental health challenges.[13]

Ohio smokers face serious health consequences; Over 20,000 Ohio adults die each year from smoking-related illnesses.[14] Moreover, four of the top five causes of death in Ohio are commercial tobacco-related causes of death (heart disease, cancer, chronic lower respiratory diseases, and stroke), and about 30% of all cancer deaths in Ohio are directly attributable to smoking. These concerns will affect younger smokers as well, as it is estimated that 259,000 children now under 18 and alive in Ohio will ultimately die prematurely from smoking.[15]

More than
20,000 Ohioans die each year
from smoking-related illnesses

Beyond the impact of tobacco use on individual health, it leads to significant economic burdens as well. It is estimated that smoking-related health care in Ohio cost $5.64 billion per year, and smoking-related productivity costs in Ohio total $5.88 billion per year. Combined, those two aspects alone lead to a total economic impact of over $11.5 billion per year in Ohio. Further, the state and federal tax burden from smoking-caused government expenditures is $793 per Ohio household.[16]

Smoking-related health care in Ohio cost
$5.64 billion per year

Another factor to consider when examining the burden of commercial tobacco in Ohio is the disparate burden of tobacco on certain subpopulations in Ohio including:[17]

Ohio adults who did not graduate high school have a smoking prevalence more than **four times higher** than adults with a college degree.

4x

Ohio adults who experience frequent poor mental health have a smoking prevalence almost **two times higher** than adults who do not experience frequent poor mental health.

2x

Ohio adults with low annual household income (<$15,000 per year) have a smoking prevalence nearly **three times higher** than adults earning $75,000 or more.

3x

Ohio adults living with a disability have a smoking prevalence **64% higher** than those without a disability.

64%

Ohio adults residing in Appalachian counties have a smoking prevalence **25% higher** than those residing in non-Appalachian counties.

25%

There are many factors over history that have contributed to these disparate burdens, including specific tobacco industry tactics to target these populations with marketing and free product to establish addiction. Policy changes such as the decision to exclude menthol from the elimination of sales of flavored cigarettes from the 2009 Tobacco Control Act has resulted in a greater proportion of death and disease in the African American population than is estimated would have occurred had this flavor, targeted for use by this population by the tobacco industry, been eliminated as part of the policy. Adverse Childhood Events (ACEs) and factors that influence access to cessation treatment and cessation medication also impact tobacco disparities.[18] The prevalence, health and economic impacts, and the disparate burden of tobacco use underscore the critical importance of immediate action to develop and implement a strategic plan to improve outcomes, especially for these Ohioans.

Tobacco Free Ohio Alliance Vision and Mission

The Tobacco Free Ohio Alliance is an association of Ohio agencies, organizations, groups and individuals who work to prevent the use of commercial tobacco products and to educate Ohioans about the harmful effects of commercial tobacco use and secondhand smoke exposure on all citizens.

Vision: An Ohio where residents are free from exposure to the risks of commercial tobacco use.

Mission: Through advocacy, education and treatment, elimination of the harmful effects of commercial tobacco use and exposure for all Ohioans.

Given that there are many agencies and stakeholders pursuing commercial tobacco control-related activities in Ohio, efforts were made to align and coordinate the TFOA 2020-2025 Strategic Plan with existing local, state, and federal efforts. Plans that were reviewed for potential alignment with the 2020-2025 Strategic Plan for a Tobacco Free Ohio include:

- **Healthy People 2030**
- **Centers for Disease Control and Prevention National State Tobacco Control Grant Priorities**
- **Ohio 2020-2022 State Health Improvement Plan**
- **The Ohio Comprehensive Cancer Control Plan**
- **2017-2019 Tobacco Free Ohio Alliance Strategic Plan for a Tobacco Free Ohio**
- Ohio Local Health Department Community Health Improvement Plans
- Priorities supported by grant funding provided to local communities by the Ohio Department of Health Tobacco Use Prevention and Cessation Program
- **Ohio Department of Aging 2020-2022 Strategic Action Plan on Aging (SAPA)**

Cross-Cutting Factors

There are several factors TFOA members feel are of paramount importance in impacting tobacco use in Ohio. These factors were carefully considered in the development of the Strategic Plan for a Tobacco Free Ohio and will continue to be considered throughout the implementation of the plan.

Health Equity

The tobacco industry's documented practice of intentionally targeting people of color and under-resourced communities have created tobacco use inequities in the state of Ohio.[19,20,21] Persistent disparities exist among African Americans; American Indians/Alaska Natives; Asian Americans, Pacific Islanders and Native Hawaiians; Hispanic/Latinos; lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals; people of low socioeconomic status; people living with a disability; individuals with behavioral health conditions (including mental health conditions and substance use disorders); and by individuals living in different geographic regions, including Appalachia. Unequal access to tobacco prevention and cessation resources and increased exposure to tobacco advertising perpetuates those inequities, particularly among people of color and populations that are under-resourced. Unequal acess to public health resources and institutional and public policies worsen these disparities.

The social determinants of tobacco use include lack of social supports, employment, civic engagement, socioeconomic and educational status, as well as discrimination, and mental health stigma among other factors. Structural determinants of tobacco use include the actions and norms of systems and policies.[22] Health equity is a public health paradigm and quality goal that aims to promote equitable access to health-related opportunities when needs are equal, provide enhanced opportunities when needs are greater, and address systemic issues that perpetuate inequalities.

Social determinants of tobacco use include:

- Lack of social supports
- Employment
- Civic engagement
- Socioeconomic and educational status
- Discrimination
- Mental health stigma

Structural determinants of tobacco use include:

The actions and norms of systems and policies.

To work toward the goal of achieving health equity, the members of TFOA resolve to value all people equally and to optimize the conditions in which people are born, grow, live, work, learn and age. We will work with other sectors to address the factors that influence health, including employment, housing, education, health care, public safety, and food access. We acknowledge that racism is a force in determining how these social determinants are distributed, which have an undeniable effect on tobacco use and other factors that influence health at the individual and population level.

Youth E-Cigarette Epidemic

The ongoing youth e-cigarette or vaping epidemic in Ohio threatens to undo decades of progress in reducing youth smoking and tobacco use rates. Prior to 2019, youth smoking rates in Ohio were near their lowest point following years of steady decline. According to the 2019 Ohio Youth Tobacco Survey, only 4.9% of Ohio high school youth reported current use of cigarettes.[23] However, from 2016 to 2019, overall tobacco use increased by 88%. This increase was largely fueled by the popularity of e-cigarettes (or vaping) products. Twenty-nine percent of high school students and 11.9% of middle school students reported using these products.[24] In the years following, national, state, and local laws have been focused on curbing youth use and access to such products. In October of 2019, Ohio passed a law prohibiting the sale of tobacco products, including e-cigarettes, to anyone under the age of 21, and in December of 2020, the federal government also raised the minimum purchasing age for purchasing tobacco products from 18 to 21[25] and instituted additional measures, such as partial flavor restrictions,[26] to seemingly curb the ongoing epidemic.

Overall tobacco use by Ohio high school youth has increased

↑88%

from 2016 to 2019

Recent findings have shown a reduction in national levels of youth e-cigarette use[27]; however, there are still more than 3.6 million youth using these products, many of which are using flavored, pre-filled pods and cartridges that often escape oversight by the FDA or fall through loopholes in current regulations. The same data shows that youth not only prefer "kid-friendly" flavors, such as fruit and candy, but also more traditional flavors such as menthol.[28]

With limited regulation of these products at the federal level, state and local public health agencies must act to supplement existing efforts through local regulation, education, and prevention. Measures such as eliminating the sale of flavored products (which include mint and menthol), tobacco retail licensures, and retailer-density regulations have shown to be promising policy tools in the fight to limit youth exposure to both tobacco advertisements and products.[29] While local public health agencies cannot change cigarette excise tax, we know that federal and state level changes in cigarette excise tax (and most likely other tobacco products) has been shown to reduce youth and adult smoking. However, these measures must work in concert with continued prevention and education efforts at the state and local level to address the dangers of tobacco use for young people in Ohio communities.

Infant Mortality and Tobacco

Reducing the infant mortality rate is a key priority in Ohio.[30] Infant mortality is defined as the death of a live-born infant before their first birthday. An infant mortality rate is the number of babies who die during the first year of life per 1,000 live births. Ohio ranks 40th nationally with an overall infant mortality rate of 6.97 compared to a national rate of 5.7 (CDC, Ohio rate 2019, national rate 2018). Especially concerning is the racial disparity in infant mortality in Ohio. In Ohio, African American infants die almost three times as often before their first birthday compared to white infants with a rate of 14.3 compared to 5.1, respectively (ODH, 2019).

The leading causes of infant deaths in Ohio are prematurity related conditions (29%), congenital anomalies or birth defects (19%), and external injuries (12%). Six percent of deaths were due to sudden infant death syndrome (SIDS). Notably, tobacco use and exposure to secondhand smoke are major contributing factors to these causes of infant death. Maternal smoking raises infants' risk for birth defects, including cleft lip and palate, and it is estimated that 23-34% of deaths due to SIDS and 5-7% of preterm related infant deaths in the United States, are attributable to smoking during pregnancy.[31] Approximately 9% of Ohio preterm births are attributable to smoking.[32]

Tobacco use and exposure to second-hand smoke are major contributing factors to the leading causes of infant death in Ohio.

Through collaborations and concerted efforts, agencies throughout Ohio are seeking to remedy the infant mortality rate. Notable programs that address tobacco use and exposure among pregnant women and mothers include Baby & Me, Tobacco Free, Moms Quit for Two, Healthy Mom/Healthy Family, and Smoke Free Families. To reflect the necessity of a holistic approach in reducing the infant mortality rate in Ohio, objectives relating to infant mortality can be found throughout the Strategic Plan for a Tobacco Free Ohio.

Communications

Communication is an issue of major importance to the success of the TFOA and its efforts. TFOA recognizes that communication is integral to the development of understanding and respect for fellow members, to the sharing of information, to the ability for members to challenge each other to think differently about problems and to find the best possible solutions to the problems we face. Strong communication networks help to inform members about current and emerging issues in tobacco prevention and control so that appropriate actions can be planned and implemented throughout the state in a way that is synergistic. Additionally, TFOA affirms that health communications are important methods by which TFOA can empower individuals and communities to affect behavioral change, adopt policies that reduce tobacco use, prevent initiation of tobacco use and limit exposure to secondhand smoke. For this reason, all workgroups for this plan were asked to consider opportunities in the development of objectives and strategies to identify what part communication can plan in achieving successful outcomes.

About the plan

The Strategic Plan for a Tobacco Free Ohio is a dynamic tool, intended to be a reference for anyone engaged in tobacco use prevention and cessation efforts in Ohio. The plan is intended to support policy, systems, and environmental change while increasing the efficient use of resources. It also serves to:

- Identify a mission, vision, values, goals, and action plan
- Sets goal posts for progress
- Provide a roadmap for partners and stakeholders
- Prevent duplication of effort and allow for integration of work and synergy

How the Strategic Plan for a Tobacco Free Ohio was Developed

In 2019, the TFOA Steering Committee called for formation of a workgroup to guide the development of a revised Strategic Plan. The group met over the course of several months and conducted a 3-week survey opportunity to gather feedback from TFOA general body members on their opinion of 2017-2019 TFOA Strategic Plan Document. The purpose of the survey was to collect information from the TFOA membership about whether changes should be kept or deleted from the 2017-2019 Strategic Plan in the development of the 2020-2025 Plan. A total of 150 TFOA members were emailed a copy of the TFOA Strategic Plan and the link to the survey and 28 members provided feedback. Workgroup plans were interrupted by response to the EVALI crisis and implementation of Ohio's Tobacco 21 law. The COVID-19 pandemic then delayed this process further.

In 2020, the Ohio Department of Health (ODH) Tobacco Use Prevention and Cessation Program (TUCPC) contracted with its external evaluator Strategic Research Group (SRG) to assist in facilitating five workgroups of TFOA members to develop the objectives and strategies for each of the five priority areas for the 2020-2025 Plan. Using the feedback from the 2019 member survey, TUPCP drafted an outline for the TFOA 2020-2025 Plan, including the objectives and strategies developed by the workgroups. This outline was shared with the TFOA Steering Committee and members and feedback was solicited during meetings and via an online survey. Revisions were made to the 2020-2025 Plan based on member feedback and the final 2020-2025 TFOA Strategic Plan was drafted by TFOA members and TUPCP staff who were most familiar with each section of the Plan. The graphics for the Plan were provided via a contract with the Health Policy Institute of Ohio.

Implementing the Plan

The 2020-2025 tobacco prevention strategic plan contains ambitious goals to achieve an Ohio where residents are free from exposure of the risks of commercial tobacco use. To facilitate collaboration and achieve the outlined goals, TFOA will:

- Convene implementation workgroups as needed for the goals.
- Conduct regular reviews on voices missing from the work and develop plans to better engage those groups and individuals.
- Review to ensure equity is being addressed throughout the plan and within goals.
- Facilitate collaboration between TFOA members, funded local tobacco groups, stakeholders, and partners working in the space to impact tobacco use rates.

Evaluating the plan

In order to mark progress and challenges, ongoing evaluation is a critical step. As with any dynamic plan, strategy adjustments to changing environments, recruitment of new partners and efforts to ensure equity is being advanced will be needed. The following steps will provide ongoing feedback:

- Workgroups will provide regular feedback to the TFOA Steering Committee and the evaluator on progress towards objectives and any challenges.
- Through updates or survey, workgroups, committees, members, and partners will share information on progress toward objectives, as well as any successes and challenges.
- An annual evaluation update will be provided to the TFOA Steering Committee and general membership, and will be posted on the **TFOA website.**
- Special attention will be given to assessment of health equity and progress being made. Challenges will be discussed and realigned as necessary to improve progress toward objectives.

How to get involved

This Strategic Plan challenges all of us to think about how we can be impactful. In addition to adding your voice and perspective to the efforts of our workgroups, below are examples of activities you might engage in, by sector:

GET INVOLVED

▶ Community Organizations

- Support efforts to equalize the tax on electronic nicotine delivery systems.
- Support eliminating the sale of all flavored tobacco products.
- Outreach and educate affordable housing providers, businesses and employees, and schools and campuses, on the benefits of smoke free policies and the dangers of secondhand smoke.
- Educate school-aged children and adolescents to prevent initiation of tobacco.
- Promote the Ohio Quitline and My Life, My Quit to constituencies, and promote affordable community-based individual and group counseling.

GET INVOLVED

▶ Employer

- Enforce the Smoke-free Work Place Law.
- Review employee health benefits plans to assure cost-free tobacco cessation benefits are available to employees and their families.
- Inform employees of available tobacco cessation benefits.
- Adopt tobacco free campus (including all outside areas and parking lots) for workplace and include e-cigarettes.

GET INVOLVED

▶ Faith Based Organizations

- Educate members on tobacco cessation services available in the community, including the Ohio Quitline and My Life, My Choice.
- Adopt tobacco-free policy on premises (including all outside areas and parking lots) and include e-cigarettes.
- Participate in No Menthol Sunday (https://centerforblackhealth.org/nomentholsunday/).

GET INVOLVED

Healthcare Provider

- Follow protocols to screen for tobacco use and to encourage youth and adult patients to quit tobacco use (Tobacco Cessation Change Package, Million Hearts -https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf).
- Refer youth and adult patients to tobacco cessation services, including to the Ohio Quitline and My Life, My Quit.
- Promote awareness of the importance of tobacco cessation through media channels and in healthcare systems.
- Offer tobacco cessation counseling services (individual or group-based).

GET INVOLVED

Health insurance, including Medicaid managed care organizations

- Provide and expand coverage for tobacco cessation therapies in compliance with United States Prevention Services Task Force recommendations.
- Continue to provide and promote, through Ohio Medicaid, open access to tobacco cessation therapies, without prior authorization requirements, limits on length of treatment, or co-payment requirements.
- Educate members about available tobacco cessation benefits.
- Increase provider knowledge and use of tobacco screening and cessation referrals for youths and adults.
- Lead quality improvement efforts to increase cessation among members.

GET INVOLVED

Hospitals

- Implement health systems change protocols to screen all patients for tobacco use and advise those who do use to quit.
- Establish and publicize tobacco cessation programs in-house or establish referrals to local programs.
- Adopt tobacco free policies on hospital campus, including e-cigarettes (including all outside areas and parking lots).
- Increase availability and promotion of affordable tobacco cessation treatment programs.

GET INVOLVED

Local Health Departments

- Educate school-aged children and adolescents to prevent initiation of tobacco.
- Offer tobacco cessation services.
- Promote the Ohio Tobacco QuitLine.
- Provide tobacco related information to residents.
- Promote tobacco-free schools, campuses, and outdoor spaces.
- Promote smoke-free multi-unit and private housing.
- Promote tobacco-free behavior health facilities.
- Public tobacco prevention or cessation media campaigns focused on priority populations.

GET INVOLVED

Local Decision Makers

- Consider policies to limit the accessibility and availability of tobacco products to youth. (Model policies are available from ODH, upon request).
- Consider policies that extend to prohibit tobacco use in public places, including parks, to prevent involuntary exposure to secondhand smoke.
- Outreach and educate affordable housing providers, businesses and employees, and schools and campuses, on the benefits of smoke free policies and the dangers of secondhand smoke.
- Advocate for increased tobacco taxes at the state or federal level. Price increases have the greatest effect on tobacco use among racial minorities, youth, and low-income individuals.

GET INVOLVED

Media

- Partner with local tobacco partners and advocates to facilitate the sharing of science-based information and the risks of tobacco use.
- Assist in communicating to disproportionately impacted populations the health risks of commercial tobacco use, deceptive marketing by the tobacco industry and ways to quit.
- Promote the Ohio Quitline and My Life, My Quit as cessation resources for adults and youth, respectively.

GET INVOLVED

Ohioans

- Quit or do not initiate tobacco use.
- Do not allow tobacco use in your home or vehicle.
- Get involved with a community organization or coalition working to prevent tobacco dependence.
- Advocate for the adoption of policy change to limit access and availability of tobacco products.

GET INVOLVED

Professional Organizations

- Make practitioners aware of tobacco cessation protocols for use with clients or patients.
- Support efforts to enact policy change to limit access, availability and exposure from tobacco products.

GET INVOLVED

School or University

- Pass a 100% tobacco- and nicotine-free school policy, including prohibition of e-cigarettes. (Model policies are available).
- Educate staff, students and parents on the risk of tobacco and nicotine use and early screening for use.
- Provide linkage to cessation resources, including the Ohio Quitline and My Life, My Quit
- Facilitate linkage with university researchers and state data collection.

Priority areas

The remainder of the plan is organized into five priority areas with objectives and strategies for achieving each priority. The plan includes specific goals to be reached by December 2025, including targets within specific populations. The five priority areas are as follows:

- Prevent Youth Tobacco Use.
- Promote Tobacco Cessation.
- Eliminate Exposure to Secondhand Smoke.
- Develop and Maintain Sustainable Infrastructure.
- Investigate, Monitor, and Evaluate Issues Associated with Tobacco Use.

Key = Equity = Communications = 2020-2022 State Health Improvement Plan (SHIP) objective

Priority Area 1:
Prevent Youth Tobacco Use

The vast majority of tobacco use begins before the age of 18 due to industry advertisements and product development that appeals to young people through advertisements and product development in order to hook the next generation of customers on nicotine products.[33] With youth smoking rates declining over the past several decades,[34] tobacco companies have now turned to e-cigarettes and other modern products that appeal to young people as a way to circumvent traditional restrictions and regulations governing the advertising and marketing of tobacco products to youth- including the use of flavors, ambiguous health claims, and targeted online marketing. [35] Over the past 10 years, rates of electronic nicotine delivery systems (ENDS) use among America's youth have skyrocketed,[36] peaking in 2019, with nearly one-in-three youth reporting use of these products.[37] These products deliver dangerous levels of nicotine which quickly form addictive habits and interfere with cognitive development during this crucial phase of life, negatively impacting key behavioral outcomes such as learning and impulse control.[38] Additionally, an ever-growing body of evidence suggests that e-cigarette use early in life leads to the use of traditional tobacco products as an adult.[39,40,41]

> Tobacco prevention and control partners must modernize the interventions used to educate and inform young people about the dangers of nicotine, as well as the regulations that govern their marketing, sale, use, and development.

In response to this new generation of products, tobacco prevention and control partners must modernize the interventions used to educate and inform young people about the dangers of nicotine, as well as the regulations that govern their marketing, sale, use, and development. The first step of this journey was completed in 2019 when Ohio passed a law raising the minimum age for purchasing tobacco products to 21 years old. In the coming years the Ohio Department of Health (ODH) Tobacco Use Prevention and Cessation Program (TUPCP) aims to improve the reach and relevance of their tobacco prevention and control education efforts by developing more modern tools to help educate the public, particularly teens and young adults, about the health risks associated with e-cigarette use. In addition to these efforts, ODH and local health departments will continue to pursue and advocate for more comprehensive tobacco control regulations in the form of tobacco retail licensing, flavor bans, and Tobacco 21 enforcement in order to more effectively protect youth, one of our most vulnerable populations, from the influences of tobacco companies and their harmful products.

In addition, The American Academy of Pediatrics (AAP) has classified children in foster care as a population of children with special health care needs. Approximately one-third of these children have a chronic medical condition, with many of these going undiagnosed and untreated before they enter the foster care system.[42] To better address all of the needs of these children, Ohio held a Child Safety Summit[43] and issued recommendations[44] for change, including for better health care and coordination of care. With the special concerns of these children, addressing the risk of tobacco exposure and use by this population of children is needed.

Objectives and Strategies

1 By 2025, increase the number of local jurisdictions in Ohio that have laws or regulations limiting the accessibility and availability of tobacco products for youth by 10% (baseline to be established by ODH TUPCP by 2022).

- Deliver education tools and opportunities for local public health districts related to Tobacco Retail License and other tobacco control regulations.
- Improve efforts to educate local county and city level officials on the benefits of Tobacco Retail License and other tobacco control measures.
- Develop model policies and strategy documents for implementing local tobacco control policies.
- Strengthen inter-governmental ties at state and local levels to improve policy process and outcomes.

2 By 2025, increase the number of K-12 school districts protected by 100% tobacco-free school policies from 31% to 54%. (ODH School Policy Database).

- Engage grassroot parent and youth-led advocacy groups on tobacco issues.
- Provide (or continue to provide) technical assistance to schools who want to have 100% Tobacco Free policies.
- Engage with new and existing state-level stakeholders such as the Ohio Parent Teacher Organization (PTO), Ohio Parent Teacher Association (PTA) and the Ohio Education Association.
- Improve outreach and educational efforts to school superintendents.
- Develop culturally competent tools for different communities (urban, suburban, rural, rural Appalachian, urban Appalachian) related to 100% Tobacco Free policies.

3 By 2025, equalize the tax on Electronic Nicotine Delivery System (ENDS) and ENDS accessories to the state tax on cigarettes (Ohio Department of Taxation Annual Report).

- Engage and utilize stakeholders as advocates for policy change.
- Engage and utilize youth advocates/champions across the state through state and local partnerships with youth-centric/youth-led organizations.
- Engage local legislators to educate them about the benefits of an ENDS tax in their communities.
- Develop educational and media materials using existing data on cost and cost savings related to this tax.

4 By 2025, support policies to protect children in foster care from secondhand smoke exposure in individual home and facilities, as well as during any transport, and include cessation screening and services as part of the medical care plan of children in foster care. (Ohio Revised Code, Ohio Administrative Code or local policy.)

- Promote inclusion of tobacco exposure risk and cessation as part of the care team discussion throughout the foster care process.
- Engage stakeholders to support policies to eliminate secondhand smoke exposure to foster children in all settings – inside home, outside within range of home/facility and within transport vehicles.

- Engage stakeholders to support integration of tobacco cessation into the medical home of foster children to systematically provide screening and cessation services.
- Encourage local county agencies to promote tobacco screening and cessation referrals for foster caregivers and children with local medical providers.[45]

5 By 2025, implement a state-wide restriction on menthol flavored tobacco products, including Electronic Nicotine Delivery Systems (ENDS) (Ohio Revised Code).

- Engage advocacy groups that can initiate grassroots support for policies in local communities.
- Improve community-based support from targeted stakeholder groups, such as faith-based organizations in African American communities.
- Develop media campaigns focused on the effects of menthol tobacco products among African American communities in order to educate about the issue.[46]

Priority Area 2:
Promote Tobacco Cessation

Quitting smoking or use of other nicotine-containing products is one of the most important things an individual can do for improved health and a longer, happier life. The 2020 Surgeon General's Report on Smoking Cessation found that smoking cessation is beneficial at any age, improving health status, enhancing quality of life, and reducing the risk of premature death, adding as much as a decade to life expectancy.[47] Smoking cessation reduces risk for many adverse health effects including reproductive health outcomes, cardiovascular diseases, chronic obstructive pulmonary disease, and at least twelve types of cancer.

Quitting smoking or use of other nicotine-containing products is one of the most important things an individual can do for improved health and a longer, happier life.

Nationally, more than two-thirds of adult smokers who tried to quit during the past year did not use evidence-based treatment.[48] Barrier-free and widely promoted insurance coverage for smoking cessation treatment increases use of services, leads to higher quit rates and is cost-effective. The Ohio Tobacco Quit Line is available to all Ohioans without restriction, which includes the five-call treatment protocol and up to eight weeks of free nicotine replacement therapy. In-person and group cessation services are offered in communities across the state.

Traditional and non-traditional healthcare providers are important in promoting tobacco cessation with patients of all ages, yet nationally four out of nine adult smokers who saw a health professional during the past year did not receive advice to quit.[49] Strategies linking smoking cessation-related quality measures with payments to clinicians, clinics, or health systems are proven to increase the rate of delivery of smoking cessation clinical treatments.[50]

Objectives and Strategies

1 By 2025, decrease the prevalence of adult smoking in Ohio from 20.8% (BRFSS, 2019) to 19.6%. (Tracked through BRFSS).

- Promote physician-to-patient cessation counseling or referral for counseling for youth and adults.
- Increase availability, affordability, and promotion of tobacco cessation treatment programs.
- Work with insurers to increase compliance with USPSTF recommendations for tobacco cessation coverage and remove barriers to accessing tobacco cessation therapies, such as prior authorization requirements, limits on length of treatment, annual limits on quit attempts, and co-payment requirements.
- Promote awareness of the importance of tobacco cessation through media channels and in healthcare systems.

2 By 2025, decrease the disparity in adult smoking prevalence by 10% from baseline among population groups with at least a 25% smoking prevalence. (Rates will be reported and tracked for each group.)

Current Baseline Prevalence: BRFSS	Baseline (2019)
Current Smoker	**20.8%**
Black, non-Hispanic	25.2%
Low-income (less than $15,000 annual household income)	37.2%
Education less than High School	41.8%
LGBTQ+	27.1%
Frequent poor mental health (14 days or more a month)	34.8%
People with a disability	29.9%

- Work with organizations that serve/represent disparate populations to employ strategies to increase awareness and promotion of tobacco cessation treatment.
- Increase training offerings focused on "Ask, Advise, Refer" intervention for use in clinical and non-clinical/community-based settings.
- Develop, conduct, and evaluate media campaigns designed to reach populations with disparate burden.
- Work with local public health systems to conduct outreach activities in settings likely to reach populations with disparate tobacco burden (e.g. church, community festivals, worksites).

3 By 2025, increase enrollment in the Ohio Tobacco Quit Line from populations with higher than a 25% tobacco use prevalence (BRFSS, 2019) by 10% from Ohio Tobacco Quit Line 2020 baseline.

- Increase provider promotion of the Ohio Tobacco Quit Line to patients, especially for populations with disparate tobacco burden.
- Develop, conduct, and evaluate media campaigns promoting the Ohio Tobacco Quit Line.
- Ensure tobacco cessation programs, including Quit Line coaches and counselors, are trained to provide specialized services to Ohio's identified populations with disparate tobacco burden.

4 By 2025, decrease the prevalence of middle school and high school tobacco/nicotine product use in Ohio from 16.5% (YTS, 2019) to 14.8% in middle schools and from 35.6% (YTS, 2019) to 32.0% in high schools. (Tracked through Youth Tobacco Survey).

- Develop, conduct, and evaluate media campaigns to promote youth cessation resources.
- Share resources with schools and health providers about the importance of early screening and intervention for nicotine product use.
- Increase nicotine product use screening and referral of youth that have initiated use.

5 By 2025, increase the percentage of Ohioans who are advised by a health care professional to quit smoking from 60.6% (BRFSS, 2019) to 66.7%. (Tracked through the BRFSS.)

- Promote physician-to-patient cessation counseling or referral for counseling for youth and adults.
- Advocate for use of peer-to-peer engagement strategies to screen and refer tobacco users being seen in clinical settings, especially for disparate populations.
- Incentivize healthcare providers to participate in training and implement the most current, evidence-based tobacco cessation methodologies.
- Work with state and national healthcare professional associations to provide easily accessible, free CME.
- Widely promote available cessation resources to healthcare providers, with special focus on accessibility and culturally-considerate services.

Priority Area 3:
Eliminate Exposure to Secondhand Smoke

Secondhand smoke (SHS) contains more than 7,000 chemicals, of which hundreds are toxic and about 70 can cause cancer. SHS causes numerous health problems in infants and children including more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome. Health conditions caused by SHS in adults include coronary heart disease, stroke, and lung cancer. Since the 1964 Surgeon General's Report, 2.5 million adults who were nonsmokers died from health problems caused by SHS exposure.[51]

There is no risk-free level of secondhand smoke exposure; even brief exposure can be harmful to health.

There is no risk-free level of SHS exposure; even brief exposure can be harmful to health.[52] Ohio passed a Smoke-Free Workplace law in 2006 to prohibit smoking in all indoor public places and places of employment. Other potential actions at the federal, state, or local level include increasing the number of comprehensive smoke-free laws and policies that prohibit smoking not just in all indoor public spaces, but also outdoor public spaces, including parks, restaurants, and bars.[53]

Additionally, the potential health impacts of secondhand vapor must be considered when implementing or evaluating tobacco-free policies. Electronic nicotine delivery systems (ENDS) emit secondhand aerosol (incorrectly called vapor by the industry) containing nicotine, ultrafine particles and low levels of toxins known to cause cancer. As of April 1, 2021, 981 municipalities, 20 states, and three territories include ENDSs as prohibited products in 100% smoke-free environments.[54]

Most people, particularly children, are exposed to SHS in homes and vehicles. In 2019, almost 7 million U.S. middle and high school students (about 25%) reported breathing SHS in their homes, and just over 6 million (about 23%) reported breathing SHS in vehicles.[55] Health communication, an evidence-based intervention, can be implemented with the goal of changing knowledge, beliefs, and behaviors regarding SHS. Providing cessation resources for tobacco users and setting boundaries around where not to smoke are other ways to protect children and adults from SHS exposure.

Health equity is a vital consideration when planning tobacco control efforts. Populations with disparate tobacco burden, including those with mental illness and/or substance abuse disorders[56,57,58] use tobacco more often and are exposed to SHS at higher rates than the general population, and this inequity leads to poorer health outcomes and premature death for these groups. Increasing the number of mental health and substance abuse facilities that adopt comprehensive tobacco-free policies can protect individuals from the dangers of SHS and reduce the acceptability of smoking among staff and clients, motivating smokers to quit and may decrease initiation of tobacco use.[59] It is also critical to communicate about resources and provide support for those impacted by policies in culturally competent ways. (Best Practices User Guide-Health Equity in Tobacco Prevention and Control, CDC, 2015).[60]

Objectives and Strategies

1 By 2025, decrease adult exposure to secondhand smoke within the past seven days from 42.0% (BRFSS, 2019) to 37.8% and decrease youth exposure to secondhand smoke within the past seven days from 47.8%(YTS, 2019) to 43.0%.

- Comprehensive smoke-free laws that extend to prohibit smoking not just in all indoor public spaces, but also to include outdoor areas of public places, including parks to prevent involuntary exposure to secondhand smoke.
- Design and implement a comprehensive, hard-hitting mass media communications campaign to change knowledge, beliefs, attitudes and behaviors affecting tobacco use; dangers of secondhand smoke, and provide tobacco users with information on resources on how to quit.
- Education and outreach to affordable housing providers, businesses and employees, and schools and campuses, on the benefits of smoke-free policies and the dangers of SHS.
- Education or brief counseling to prevent initiation of tobacco use among school-aged children and adolescents.

2 By 2025, increase the percentage of Mental Health Facilities that adopt comprehensive smoke-free policies from 51% (N-MHSS, 2019) to 55% and the percentage of Substance Abuse Facilities that adopt comprehensive smoke-free policies from 34% (N-SSATS, 2019) to 38.0%.

- Facilitate education and promotion of the impact of tobacco-free grounds on changing social norms on tobacco use and, therefore, initiation and use of tobacco. Communicate about resources in culturally competent ways.
- Provide support and/or technical assistance to facilities in adopting model policy language, including resources, toolkits, and cessation resources for employees and clients.

3 By 2025, reduce adult exposure to secondhand vapor from vaping/e-cigarette use from 21.6% (BRFSS, 2019) to 19.4% and reduce youth exposure to secondhand vapor from vaping/e-cigarette use from 24.5% (ATS, 2019) to 22.1%.

- Design and implement a comprehensive, hard-hitting mass media communications campaign to change knowledge beliefs, attitudes and behaviors affecting tobacco use; and provide tobacco users with information on resources on how to quit.
- Engage youth and youth advocacy resources to promote these efforts and like efforts in their own communities to build statewide support.
- Education or brief counseling to prevent initiation of tobacco use among school-aged children and adolescents.
- Counter-marketing to reduce, displace, or counteract tobacco industry advertising, sponsorship and promotions.
- Comprehensive smoke-free laws, including e-cigarettes, that prohibit smoking in all indoor areas of workplaces and public places to prevent involuntary exposure to secondhand smoke.

4 By 2025, all property owned or managed by the State of Ohio will be 100% smoke-free, with no designated smoking areas (State of Ohio Policy, Department of Administrative Services).

- Develop request for the Governor's Office to implement an Executive Order.
- Collaborate to produce a document in support of smoke-free state properties that can be used to promote the initiative to decision makers.
- Utilize media advocacy to educate about implementation of new policy for state employees who will be impacted by policy.
- Communicate resources, in culturally competent ways, (i.e. cessation resources like Ohio Tobacco Quit Line) to state employees who will be impacted by policy.

Priority Area 4:
Develop and Maintain a Sustainable Infrastructure

> Comprehensive tobacco control programs and policies have been proven effective for controlling tobacco use.

According to the 2014 Surgeon General's Report on The Health Consequences of Smoking, comprehensive tobacco control programs and policies have been proven effective for controlling tobacco use. Further gains can be made with the full, forceful, and sustained use of these measures.[61] Investments in state tobacco control programs have a strong effect that grows as programs continue to dedicate resources to curbing tobacco use over many years. The return on investment for Comprehensive State Tobacco Control programs has been demonstrated to be significant, mostly due to decreases in tobacco-related health conditions including heart attack, stroke, and cancer.[62]

A functioning program infrastructure includes five core components: networked partnerships, multilevel leadership, engaged data, managed resources, and responsive plans/planning.[63] The objectives of this section are designed to facilitate action and progress in each of the core components of infrastructure.

Objectives and Strategies

1 By 2025 at least 50% of TFOA members will report having worked on an objective of the Strategic Plan for a Tobacco Free Ohio (Membership survey, SRG).

- Conduct promotions of the TFOA Strategic Plan for a Tobacco Free Ohio (i.e., executive summary, recorded webinars, reminders and updates, shareable PowerPoint documents).
- Solicit TFOA membership commitment to work on plan objectives and incorporate reminders and updates into general meetings.
- At least annually, review and report progress toward strategic objectives.
- Recruit TFOA members to work on strategic objectives where expertise or commitment beyond current membership is needed.
- Identify health disparities-related activities throughout the Strategic Plan; create a fact sheet with the objectives in the Plan related to disparities to assist with focusing efforts on improvement in health equity.

2 By 2025, strong multi-level leadership for tobacco control in Ohio will be demonstrated by achievement of at least two statewide tobacco control policy changes (i.e., equalizing tax for other tobacco products to taxes placed on cigarettes, increasing tax on e-cigarettes and accessories, increasing cigarette tax by at least $1.00 per pack, increasing the price of tobacco through non-tax strategies) (Ohio Revised Code).

- Convene a multi-level, multi-cultural policy workgroup that will evaluate and recommend potential statewide tobacco control policy efforts that address racial and other disparities.
- Identify, educate, and engage champions and other partners that will help to build support for identified policy initiatives.
- Use partnership and stakeholder resources to communicate about and build support for policy change.

3 By 2025, TFOA membership will complete at least three collaborative projects (through workgroups) that address objectives of the Strategic Plan for a Tobacco Free Ohio, at least one of which will address a disparate population (Annual Strategic Plan Evaluation).

- Establish at least three collaborative projects led by TFOA member agencies or state agency partners to be the subject of workgroups, at least one of which will be focused on a population experiencing health inequity related to tobacco.
- Identify and recruit members who will expand TFOA expertise on collaborative projects.
- Communicate regularly with partners, stakeholders and potential partners about projects and their progress.

4 By 2025, increase the amount of funding provided to Ohio's Tobacco Use Prevention and Cessation Program by 20% from State Fiscal Year 2022 appropriation (ODH TUPCP Budget Report).

- Develop a cohesive and specific statement of need for additional funding and how it will be used, to include information on how it will be used to narrow disparity gaps.
- Identify, engage, and educate champions (especially in legislature).
- Identify potential sources of funding (e.g., state, tax revenue).
- Create and implement plan to increase funding.

5 By 2022, clearly identify geographic regions or counties in Ohio that are most impacted by tobacco use and by 2025, increase the number of these areas that are funded or that receive increased funding or support to address tobacco prevention and control (Report from TFOA data group or ODH TUPCP).

- Use existing and innovative data to determine Ohio geographic regions with highest need for tobacco interventions and those needing assistance to build capacity to address the issue.
- Develop and make available training and resources to promote interest in tobacco control and prevention and to increase capacity to address the issue.
- Facilitate collaborations/mentorships between high need counties/regions with jurisdictions with a history of grant writing success to increase funding to high need areas.

6 By 2025, at least 90% of TFOA members will report having used tobacco data within the past year to promote public health goals (e.g., program planning, implementation, evaluation, promotion of program successes) (Membership Survey, SRG).

- Identify and promote existing data and sources for use by TFOA members.
- Data partners will share available data at each general meeting and through established alternative communication channels.
- TFOA members share how they have used data.
- Data needs shall be a regular part of meeting evaluation surveys.
- Promote the use of available data that help to address health inequities.

Sustainability plan

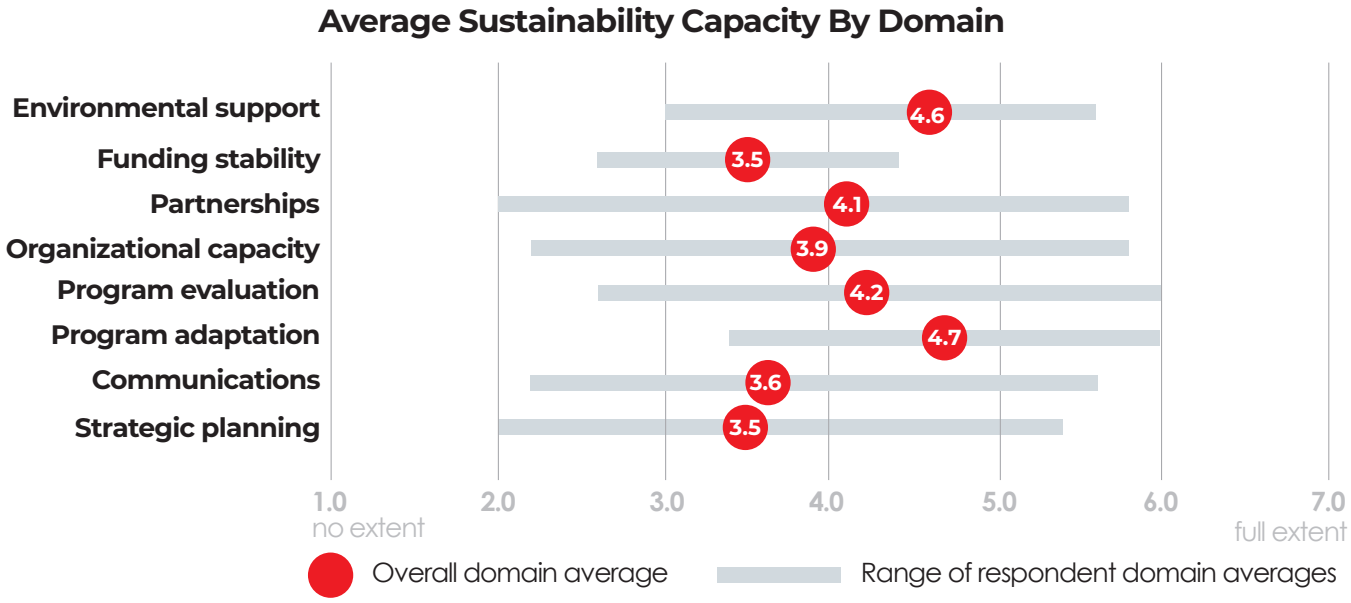
Tobacco prevention and control programs have been proven to play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness. Evidence continues to mount supporting the critical role that comprehensive state and local tobacco control programs play in keeping young people from starting to smoke, increasing the number of people who successfully quit, and decreasing nonsmokers' exposure to secondhand smoke.

In order to evaluate the sustainability of Ohio's Comprehensive Tobacco Prevention and Control Program, which includes the Ohio Department of Health's Tobacco Use Prevention and Cessation Program (TUPCP) as well as the TFOA and extended partners, Ohio participated in the Plans, Actions, and Capacity to Sustain Tobacco Control (PACT) study. A CDC funded effort to increase the capacity for sustainability among evidence-based tobacco control programs.

Through participation in the PACT study, TUPCP brought together a group of partners to assess the sustainability of Ohio's Comprehensive Tobacco Prevention and Control Program and to identify ways to improve its sustainability. Assessments have been conducted using PACT's Program Sustainability Assessment Tool (PSAT), which assesses sustainability over several contextual domains (see graphic below).

Once the assessment is completed, it is important to consider program needs, goals, and the various capabilities of each stakeholder at the table. PACT recommends that low scores do not necessarily indicate low sustainability in the program but may indicate opportunities for focusing the plan. They also recommend the plan be reviewed annually and that programs focus on no more than one to two domains at a time.

The combined PSAT scoring from Ohio's group in 2020 was as follows:



Since the time of this assessment, TUPCP and their evaluation contractor, Strategic Research Group, have conducted a formal evaluation of program infrastructure which included partnership evaluation of communication efforts and strategic planning. Recommendations from this evaluation have been implemented with the aim of improving sustainability in those domains. The organizational structure domain has been chosen as an emphasis for the first annual sustainability action plan as part of the TFOA Strategic Plan.

Before December 31, 2021, TFOA and TUPCP will:

- Conduct partnership meetings to determine gaps in organizational capacity of TFOA and TUPCP as they exist in relation to strategic priorities of the TFOA Strategic Plan.
- Identify the steps and resources necessary to address these gaps.
- Review the infrastructure Evaluation conducted and identify remaining recommendations that need to be addressed related to organizational capacity.
- Identify the steps and resources necessary to address these recommendations.
- Complete a sustainability action plan addressing organizational capacity to be implemented in the first year of the TFOA Strategic Plan implementation.

Before December 31, 2022, TFOA and TUPCP aimed to:

- Conduct a PSAT assessment to determine changes or progress to PSAT scoring for organizational capacity and to identify potential sustainability targets for 2023.
- Complete a revised/updated sustainability action plan for 2023.

Priority Area 5:

Investigate, Monitor, and Evaluate Issues Associated with Tobacco Use

Surveillance and evaluation are critical components of a successful tobacco control program and a successful comprehensive tobacco program, especially in times of limited resources. Current, available, and accurate surveillance data assist in guiding program and policy decisions. Evaluation of program activities provides accountability and helps to demonstrate effectiveness.

Evaluation of program activities provides accountability and helps to demonstrate effectiveness.

Surveillance efforts include analyzing existing data and identifying new data sources to determine high-risk and disparate populations, identify emerging health problems, and monitor trends to better develop, track, and evaluate public health programs and policies.

Evaluation efforts must focus first on developing a strategic evaluation plan that is integrated with relevant strategic plans (e.g., Ohio State Health Improvement Plan). Pursuant to the Centers for Disease Control and Prevention (CDC) Best Practices Guidelines (2014), evaluation efforts will then systematically collect information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programming, and increase understanding. Evaluation of this Strategic Plan is discussed in the implementation section of this plan. Evaluation of the Comprehensive Tobacco Program is conducted under an external evaluation contract managed by the Ohio Department of Health and includes regular input from TFOA members and other tobacco prevention and control stakeholders and partners.

The objectives and strategies of this section are focused on establishing a data committee to coordinate multi-agency tobacco data efforts to increase sharing of data, to facilitate the ease of use of available data, to identify and implement strategies to improve data collection as traditional methods become more expensive and difficult to obtain, and to foster partnerships with Ohio researchers to promote the translation of practice-based research.

Objectives and Strategies

1 By 2022, establish a collaborative data interest committee to coordinate multi-agency tobacco data efforts to increase sharing and use (Notes and quarterly reports from data interest committee).

- Create a standing data interest committee composed of a broad range of TFOA members as well as representatives from populations disparately affected by tobacco, academic institutions, and state and local partners and stakeholders.
- Identify needed resources for data interest committee work (e.g., expertise, funding).
- Review and identify best practices to inform work for other data initiatives of the Strategic Plan.
- Review existing data or collect data as necessary to determine how tobacco stakeholders are using data and to determine what data needs or gaps exist.
- Identify ways to enhance the usability and availability of tobacco data for tobacco control efforts (e.g., ability to disaggregate data by region or subpopulation).
- Develop and implement a data dissemination plan to reach a broad audience of stakeholders and potential stakeholders (e.g., data listserv, newsletters, presentations, fact sheets).

2 By 2025, facilitate the development and implementation of a Tobacco Toolkit (including data resources, links, usage guidance documents, and online trainings) for stakeholders and partners aimed at enhancing capacity to interpret and use data (Published or electronically available toolkit).

- Create a TFOA workgroup to develop toolkit.
- Identify or collect information on data competency of TFOA membership and tobacco stakeholders to inform toolkit development and trainings.
- Develop workplan and timeline for toolkit development.
- Conduct user review of toolkit prior to finalization to determine if it will meet needs of members and stakeholders, including review of cultural competence and applicability to populations suffering disparate burden of tobacco use.
- Finalize toolkit and trainings and create dissemination plan.
- Promote and provide ongoing training and technical assistance for toolkit use.

3 By 2025, identify and implement at least three strategies to improve or enhance data collection on health inequities of tobacco impact and to improve regional or local data (Evidence of Implemented Strategies).

- Review existing data to determine potential achievable methods to enhance disaggregated data.
- Identify potential resources to achieve better disaggregated data (e.g., recruitment of partners with enhanced skills at data disaggregation, increased funding for additional data collection).
- Identify and promote non-traditional sources of disaggregated data (e.g., technical assistance for increased local data collection, use of expanding national databases that estimate disaggregated data, use of market data such as Claritas).
- Explore and share information about how to overlay multiple data sources to gain better understanding of smaller geographic areas (e.g., Health Opportunity Index).
- Facilitate coordination of local and state surveys to provide larger sample sizes for disaggregation.

4 By 2025, identify, create, and implement three new, innovative data-collection methods (e.g., telephone surveys) (Demonstrated use of at least three new strategies by TFOA partners).

- Identify and recruit experts on innovative data collection to inform potential methods.
- Identify and obtain resources to implement at least three identified innovative data collection methods (e.g., web panels, increasing incentives, methods to improve buy-in).
- Pilot at least three innovative methods of data collection, at least one of which will focus on health inequities/disparities.
- Disseminate findings from pilot projects to a broad range of stakeholders to inform decisions on ongoing data collection methods.

5 At least annually, TFOA will foster partnerships between members and researchers to assist in translation of innovative, practice-based research, with a focus on improving health equity (Notes from annual meetings).

- Identify tobacco researchers doing work that is translatable into practice by stakeholders (e.g., literature review, potential workgroup).
- TFOA will hold one general meeting per year devoted to promotion of Ohio research findings (including research that works to reduce tobacco-related disparities).
- Work to recruit more research-based members to TFOA.
- Facilitate dissemination of research findings (tobacco conference, updates at TFOA meetings, member publications, and communication networks).
- Identify potential existing research partnerships to leverage recruitment or dissemination of applicable findings to other tobacco stakeholders.

Appendix

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Greg Stein	Ohio Department of Health: Tobacco Use Prevention and Cessation Program	Youth Prevention
Jennifer Jones	Ohio Department of Health: Tobacco Use Prevention and Cessation Program	
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Matt Kretovics	Ohio Department of Health: Tobacco Use Prevention and Cessation Program	Youth Prevention Lead
Cresha Louks	Ohio Department of Health: Tobacco Use Prevention and Cessation Program	
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Karin Carlson	Ohio Dept. of Mental Health and Addiction Services	
David Ellsworth	Ohio Disability and Health Program	Infrastructure, Equity Lead
Yiping Yang	Ohio Disability and Health Program	
Zaynab Al-Abdali	Ohio Department of Health	Surveillance
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Erika Trapl	Case Western Reserve University	Surveillance
Jolene Defiore-Hyrmer	Ohio Department of Health	Surveillance
Kirstan Duckett	Ohio Department of Health - Maternal and Child Health	Surveillance
Jill Jackson	Ohio Department of Education	Policy

Glossary

Commercial Tobacco: Some American Indian or First Nation tribes use tobacco as a sacred medicine and in ceremony to promote physical, spiritual and community well-being. Sacred tobacco is traditionally grown by First Nations tribes. Sacred tobacco is different from commercial tobacco, which is tobacco that is manufactured and sold by the commercial tobacco industry, and is linked to addiction, disease, and death. Commercial tobacco is mass produced and sold for profit. When the report references tobacco we are referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

Disability: any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). There are many types of disabilities, such as those that affect a person's: A) Vision B) Movement C) Thinking D) Remembering E) Learning F) Communicating G) Hearing H) Mental health and I) Social relationships.
Although "people with disabilities" sometimes refers to a single population, this is a diverse group of people with a wide range of needs. Two people with the same type of disability can be affected in very different ways. Some disabilities may be hidden or not easy to see.

Electronic cigarette: devices that typically deliver nicotine, flavorings, and other additives to users via an inhaled aerosol. These devices are referred to by a variety of names, *including e-cigarettes*, *e-cigs*, *e-hookahs*, *mods*, *vape pens*, *vapes*, and *tank systems*. (SGR)

Electronic Nicotine Delivery System (ENDS): battery-operated devices that produce an aerosol or vapor instead of smoke. (Truth initiative)

Health disparity: preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. (CDC)

Health equity: achieved when every person can attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. (CDC) Note that this is a goal that we must continually strive toward in our public health efforts.

Hookah: water pipe/pipes that is/are used to smoke specially made tobacco that comes in different flavors. Hookah is also called *narghile*, *argileh*, *shisha*, *hubble-bubble*, and *goza*. (CDC)

Low Socioeconomic Status: Characterized as adults who have lower levels of educational attainment, who are unemployed, or who live at, near, or below the U.S. federal poverty level.

Masters Settlement Agreement (MSA): accord reached in November 1998 between the state Attorneys General of 46 states, five U.S. territories, the District of Columbia and the five largest tobacco companies in America concerning the advertising, marketing, and promotion of tobacco products

Medicaid: one of six Centers within the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Medicaid provides health coverage to low-income people and is one of the largest payers for health care in the United States.

Pharmacotherapy: treatment using medications. (NIH)

Secondhand Smoke: smoke from burning tobacco products, such as cigarettes, cigars, or pipes, or smoke that has been exhaled by the person smoking. (CDC)

Secondhand Vapor: Vapor released from an e-cigarette into the environment or exhaled by a person using a e-cigarette or vaping product. The long-term health effects are still unknown because products are relatively new. Aerosol vapors have been shown to include harmful substances such as ultrafine particulates and various other toxins, including several cancer-causing agents.

Smoking: inhaling, exhaling, breathing, or burning any lighted or heated tobacco product or plant or similar product, in any manner or form for the purpose or use of emitting smoke.

Social Determinants of Health: the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. (WHO)

stand: Ohio's youth-led tobacco counter-marketing campaign.

Tobacco Cessation: stopping or quitting using tobacco (e.g., cigarettes, cigars, smokeless tobacco). Tobacco users often require multiple quit attempts and use cessation methods such as counseling and/or medications to aid them in stopping tobacco use. (CDC)

U.S. Department of Housing and Urban Development (HUD): a U.S. government agency created in 1965 to support community development and home ownership.

Resources

Health Equity

Health Equity in Tobacco Prevention and Control: Best practices to achieve health equity in tobacco prevention and control.

Cessation

Surgeon General Reports on Tobacco : Archive of all Surgeon General reports on tobacco
Surgeon General Report on Smoking Cessation-2020: SG 2020 materials, including Consumer Guide
Clinical Practice Guidelines-2008: A link to the clinical practice guidelines for the treatment of tobacco dependence
CDC Best Practices for Comprehensive Tobacco Control Programs: Best practice documents, including cessation and the Cessation Consumer Guide
Million Hearts Tobacco Cessation Change Package: New resource document for tobacco cessation treatment in clinical practices
American Academy of Family Physicians Tobacco Cessation Resources: Link to tobacco cessation resources, including a toolkit and one pagers

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